

Clear Choice Health Plans

Summary of Benefits

	<i>Medicare</i>	<i>Non-Medicare</i>	
		In-Plan	Out-of-Plan
SERVICE AREA	See service information on pages 18 and 19		
PROVIDERS	Plan physicians and hospitals		
LIFETIME MAXIMUM	Unlimited	\$2,000,000	
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM	None	\$2,000 per Individual does not include deductible	\$6,000 per Individual does not include deductible
CALENDAR YEAR DEDUCTIBLE	None	\$200 per Individual \$600 per Family	\$1,000 per Individual \$3,000 per Family
OFFICE VISIT	\$10 co-pay	*\$15 PCP/\$25 specialist (no deductible)	30% co-insurance after deductible
PREVENTIVE CARE	\$10 co-pay	\$15 PCP/\$25 specialist (no deductible)	30% co-insurance after deductible
LAB, X-RAY & DIAGNOSTIC PROCEDURES	Covered in full	20% co-insurance after deductible	30% co-insurance after deductible
HOSPITAL CARE	Covered in full	20% co-insurance after deductible	30% co-insurance after deductible
EMERGENCY <ul style="list-style-type: none"> • Urgent Care • Ambulance • Emergency Room 	<ul style="list-style-type: none"> • \$10 co-pay • \$50 co-pay, waived if admitted • \$50 co-pay, waived if admitted 	<ul style="list-style-type: none"> • \$25 co-pay (no deductible) • 20% co-insurance (no deductible) • \$100 co-pay, waived if admitted 	<ul style="list-style-type: none"> • 30% co-insurance after deductible • 20% co-insurance (no deductible) • \$100 co-pay, waived if admitted
SKILLED NURSING	Covered in full in a Medicare-certified facility for up to 100 days	20% co-insurance after deductible	30% co-insurance after deductible
ROUTINE EYE EXAM & EYE GLASSES	\$120 combined benefit every 24 months for eye exam and glasses	Not covered	Not covered
ALTERNATIVE CARE	\$10 co-pay Medicare-covered chiropractic services only	\$25 co-pay (no deductible)	
PRESCRIPTION DRUGS	See pages 28 and 29		

This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

* Must select a Primary Care Physician (PCP)

Revised Premium Rates

RHIA Contribution Premium Rates

The monthly premiums shown below are after the \$60 Retirement Health Insurance Account (RHIA) contribution. More information on the RHIA contribution and eligibility can be found on page 11 of this handbook.

RETIREE WITH MEDICARE	\$89.17
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$231.76
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$727.78

Rates are effective January 1, 2006 through December 31, 2006.

* Family includes spouse and/or dependents enrolled in the PERS plan.

Non-Contribution Premium Rates

The monthly premiums shown below are without the contribution from RHIA or Retiree Health Insurance Premium Account (RHIPA). More information on RHIA and RHIPA contributions and eligibility can be found on pages 11 and 12 of this handbook.

RETIREE WITHOUT MEDICARE	\$594.57
RETIREE WITHOUT MEDICARE FAMILY* WITHOUT MEDICARE	\$1,233.18
RETIREE WITHOUT MEDICARE FAMILY* WITH MEDICARE	\$737.16
RETIREE WITH MEDICARE	\$149.17
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$291.76
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$787.78

Rates are effective January 1, 2006 through December 31, 2006.

* Family includes spouse and/or dependents enrolled in the PERS plan.